Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PROVIDENCE MEMORIAL HOSPITAL
c/o LAW OFFICES OF P. MATTHEW O'NEIL
6514 MCNEIL DRIVE BLDG 2 SUITE 201
AUSTIN, TX 78729

Respondent Name

AMERICAN HOME ASSURANCE CO

MFDR Tracking Number

M4-07-4346-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
19

MFDR Date Received

MARCH 12, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 16, 2007: "Please accept this letter and attached documentation as a formal request to appeal your underpayment of benefits on the above referenced claim. Your plan did not remit the appropriate reimbursement of services rendered; in reference to The Texas Department of Workers Compensation Chapter 134 page 17and 18. According to worker compensation statues the stop-loss threshold is reached once charges exceed $40,000.00 applying a 25% discount 75% reimbursement. Providence Memorial Hospital submitted a claim for a total charges of $133,321.05- (minus) revenue codes 278 of $56,022.30 = $77,298.75 x (multiply) by 25%=$19,324.69."

Amount in Dispute: $69,031.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 4, 2007: "This is a medical fee dispute arising from an inpatient hospital surgical admission, dates of service 06/23/2006 to 06/28/2006. Requestor billed a total of $133,321.05. The Requestor asserts it is entitled to reimbursement in the amount of $99,990.78, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges … There is no evidence submitted by the hospital demonstrating that the service provided by the hospital were unusually extensive. There is no evidence of "complications, infections, or multiple surgeries" requiring additional services by the hospital."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
June 23, 2006 through June 28, 2006	Inpatient Hospital Services	$69,031.93	$807.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated November 21, 2006

- W1 – Workers compensation state fee schedule adjustment
- 42 – Charges exceed our fee schedule or maximum allowable amount
- 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed to the division by the requestor and respondent as noted above is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, and 28 Texas Administrative Code §134.401(c)(6), the division will address whether the requestor demonstrated that: audited charges ***in this case*** exceed $40,000; the admission and disputed services ***in this case*** are unusually extensive; and that the admission and disputed services ***in this case*** are unusually costly.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement asserts that "According to worker compensation statues the stop-loss threshold is reached once charges exceed $40,000.00 applying a 25% discount 75% reimbursement." The requestor presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in

dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute that constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was five days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of five days results in an allowable amount of $5,590.00.
   - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." Review of the submitted documentation provided by the provider finds no itemized statement provided to determine the charges billed under revenue code 250. For that reason, reimbursement for these items cannot be recommended.
   - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $2,758.00 for revenue code 390 – Blood Processing. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 390 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
   - Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, no invoices or a itemized statement were found to support the cost of the implantables billed. For that reason, no additional reimbursement is recommended.

   The division concludes that the total allowable for this admission is $5,590.00. The respondent issued payment in the amount of $4,782.13. Based upon the documentation submitted, additional reimbursement in the amount of $807.87 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to

additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $807.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/20/12
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.